ELDER CARE FINANCIAL PLANNING QUESTIONNAIRE (MARRIED)

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File # ________ Date___________

This form is extremely important. Your accuracy and completeness in responding will help us best represent you. Please fill in what you can and bring the completed form with you to the appointment.

rev. 6-09

NOTE: PLEASE BRING TO OUR MEETING: COPIES OF RECENT BROKERAGE, BANK, AND ANNUITY STATEMENTS, INFORMATION ABOUT SOCIAL SECURITY AND OTHER INCOME, AS WELL AS POWERS OF ATTORNEYS, WILLS, TRUSTS, AND OTHER PLANNING DOCUMENTS

CLIENT INFORMATION:

(Husband) Full Name____

(Wife) Full Name ______________________________________

Street Address____

City____ State___________ Zip__________

Telephone:_______________________

May we correspond with you by e-mail? Yes ☐ No ☐ If so, state e-mail address: __________________

For whom is the planning being done? (Who is the ill spouse?) ____________________________________

If ill spouse is no longer at home, where is he/she currently?
Currently living at ____

CLIENT/REPRESENTATIVE:

Note: If senior is unable to act as the client or has asked another to represent him or her in meeting with attorney, please provide the following information.

Client or Representative(s): ____

Relationship to Senior(s): ____

Address(es): ____

____

Contact Telephone Number(s): _______________________ _____________________

May we correspond with you by e-mail? ___ Yes ___ No If so, state e-mail address: _______________

A. SENIORS' PERSONAL DATA

	HUSBAND			**WIFE**	
Age & Birth Date _________ _______________			Age & Birth Date _________ __________________		
Social Security No.________________________			Social Security No.______________________		
U.S. Citizen?	Yes ☐	No ☐	U.S. Citizen?	Yes ☐	No ☐
Veteran?	Yes ☐	No ☐	Veteran?	Yes ☐	No ☐

Existing Documents: **HUSBAND** **WIFE**

1. Do the Spouses have:

	HUSBAND		WIFE	
Durable Power of Attorney?	Yes ☐	No ☐	Yes ☐	No ☐
Health Care Power of Attorney?	Yes ☐	No ☐	Yes ☐	No ☐
Living Will?	Yes ☐	No ☐	Yes ☐	No ☐
Valid Will?	Yes ☐	No ☐	Yes ☐	No ☐
Revocable Living Trust?	Yes ☐	No ☐	Yes ☐	No ☐
Other Planning Documents?	Yes ☐	No ☐	Yes ☐	No ☐

Describe: ____

Is the Ill Spouse competent to execute documents? Yes ☐ No ☐ ______________________

PLEASE BRING COPIES OF EXISTING DOCUMENTS TO OUR FIRST MEETING.

B. <u>MEDICAL DATA</u>

1. <u>HEALTH</u>

(a) Name of Ill Spouse ____

Diagnosis ____

Prognosis ____

Course of Treatment ____

Where Ill Spouse Currently Resides ____

(b) Name of Well Spouse ____

Health of Well Spouse ____

Where Well Spouse Currently Resides ____

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis. ____

2. <u>PHYSICIAN</u>

(a) (Husband)

Full Name of Primary Physician ____

Street Address____

City____ State__________ Zip____________

(b) (Wife)

Full Name of Primary Physician ____

Street Address____

City____ State__________ Zip____________

3. <u>HEALTH INSURANCE</u>

Does the ill spouse have private health insurance or Medicare Supplemental Insurance? Yes ☐ No ☐

Insurance Carrier: ______________________________

Cost per month? ______________

Medicare Part B? Yes ☐ No ☐ Long Term Care Insurance? Yes ☐ No ☐

If so, please bring policy to meeting.

C. **MONTHLY INCOME**

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$_____________	$_____________
Retirement/Pension Benefits (Gross)	$_____________	$_____________
VA Pension/Disability Benefits	$_____________	$_____________
Annuity Income	$_____________	$_____________
Other Income	$_____________	$_____________
TOTAL MONTHLY INCOME	= $_____________	= $_____________

Will the pension benefit continue to benefit the retiree's widow? Yes ☐ No ☐

Will the widow's benefit be less than the retiree's? Yes ☐ No☐ If so, what percentage will continue? _____________

D. **ASSETS/LIABILITIES** Please insert the **value** of each asset/liability in the appropriate space.
Use back side for multiple accounts and CD's. If assets are jointly held with another (child, etc., indicate below).

ASSETS (explanation if necessary)		Owned by WIFE Value	Owned by HUSBAND Value	JOINTLY OWNED Value (With Whom?)	**(OFFICE USE ONLY)** COUNTABLE ASSETS
RESIDENCE (ASSESSED VALUE)					
AUTOMOBILE					
CHECKING ACCOUNTS					
SAVINGS ACCOUNTS					
MONEY MARKET ACCOUNTS					
CERTIFICATES OF DEPOSIT					
IRA'S					
MUTUAL FUNDS					
STOCKS & BONDS					
ANNUITIES					
OTHER REAL ESTATE					
CASH VALUE - LIFE INSURANCE (Total from Sch. H)					
PREPAID FUNERAL AND BURIAL PLOTS					
OTHER					
TOTALS					

(Attach additional information if necessary)

E. **MONTHLY EXPENSES (Excluding Home)**
(Home/household expenses on next page)

$________________	Monthly Nursing Home/Assisted Living Cost
$________________	Monthly Prescription Cost
$________________	Monthly Supplies/Incontinent Cost
$________________	Health Insurance Premiums
$________________	Caregiver Costs
$________________	Other ____________________________
= $________________	**Total Monthly Non-Shelter Living Expenses**

The facility is paid up through ____ (month/year).

F. **HOME/SHELTER EXPENSES**

$________________/month	Rent/Mortgage
$________________	Annual Real Estate Taxes (City and County)
$________________/month	MLG&W Utilities (Water, Sewer, Heat, Electric & Telephone) (monthly average of 12 months)
$________________/______	Homeowner's (House) insurance premium (indicate annual or monthly)
$ _______________/month	Household upkeep and maintenance expenses
$________________/month	Condominium/Association fees
$________________	**Total Average Monthly Housing Expenses**

G. **GIFTS**

Please list gifts made in excess of $1,000 in any one year, to an individual or group of individuals, within the past 5 years:

Recipient________________________________ Date _______________ Amount __________

Recipient________________________________ Date _______________ Amount __________

Recipient________________________________ Date _______________ Amount __________

Recipient________________________________ Date _______________ Amount __________

Have you ever filed a Federal Gift Tax Return? Yes ☐ No ☐
If so, please state details____

H. <u>LIFE INSURANCE</u> If any insurance is from a Term or Group Policy, check Term in box. If it is Burial Insurance, check in box.

<table>
<tr><th>Insurance Company</th><th>Indicate Type</th><th>Values*</th><th>Who is the:</th><th>Owner</th></tr>
<tr><td rowspan="2"></td><td rowspan="2">Term [ ]</td><td>Face:</td><td>Insured:</td><td rowspan="2"></td></tr>
<tr><td>Cash:</td><td>Benefic.:</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">Term [ ]</td><td>Face:</td><td>Insured:</td><td rowspan="2"></td></tr>
<tr><td>Cash:</td><td>Benefic.:</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">Term? [ ]
Burial? [ ]</td><td>Face:</td><td>Insured:</td><td rowspan="2"></td></tr>
<tr><td>Cash:</td><td>Benefic.:</td></tr>
</table>

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, check the annual statement from the company or call the insurance company directly.

***Include the <u>Total Cash Value</u> of the life insurance in the Life Insurance line in Section H.**

I. <u>CHILDREN</u> (if applicable)

1. ______________________________ Telephone: ______________
Name
______________________________ Age: ____________
Street Address
______________________________ Married? ____ Divorced? _____
City, State, Zip
Any Children? If so, how many? ______

2. ______________________________ Telephone: ______________
Name
______________________________ Age: ____________
Street Address
______________________________ Married? ____ Divorced? _____
City, State, Zip
Any Children? If so, how many? ______

3. ______________________________ Telephone: ______________
Name
______________________________ Age: ____________
Street Address
______________________________ Married? ____ Divorced? _____
City, State, Zip
Any Children? If so, how many? ______

4. ______________________________ Telephone: ______________
Name
______________________________ Age: ____________
Street Address
______________________________ Married? ____ Divorced? _____
City, State, Zip
Any Children? If so, how many? ______

(Attach page if additional room is needed)

Are any of the children blind or disabled? Yes ☐ No ☐

Have all of the children completed their education? Yes ☐ No ☐

Are any of the children receiving SSI or other form of Government entitlement payments? Yes ☐ No ☐

Do any of the family members have any financial or health problems? Yes ☐ No ☐
If so, please explain in conference.

Do any of the children or siblings live with you in Senior's home? Yes ☐ No ☐

If yes, name of child or sibling: ___________________________________ For how long? ____________________

J. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes ☐ No ☐
If yes, please explain ____
____

K. REFERRAL

By whom were you referred to this office? May we contact them to thank them? __________
Name____
Street Address____
City____ State____ Zip_____________

L. CERTIFICATION

The undersigned hereby affirms the information herein is accurate to the best of undersigned's knowledge. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

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